Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

EL PASO SPECIALTY HOSPITAL
1755 CURIE DR STE A
EL PASO TX 79902

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number: 54

MFDR Tracking Number

M4-03-5076-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated on the Table of Disputed Services: "F&R according to our region."

Amount in Dispute: $13,114.02

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary as stated on the Table of Disputed Services: "There is no MAR for outpatient hospital or ASC services. Commission Rule 134.1(f) states reimbursement for services not identified in a fee guideline shall be reimbursed at fair and reasonable consistent with Section (b) of 413.011 of the Labor Code. TWCC requires reimbursement to be 'fair and reasonable'. Additionally, an EOB is not evidence of a methodology of any kind The Commission has rejected paying a percentage of billed charges as a valid payment methodology." TMI's payment is consistent with the fair and reasonable criteria established in Section 413.011(b) of the Texas Labor Code."

Response Submitted by: Texas Mutual Insurance Co., 221 W. 6th Street, Ste. 300, Austin, TX 78711

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
December 3 – 4, 2002	Outpatient Surgery	$13,114.02	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the

absence of an applicable fee guideline.

3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. This request for medical fee dispute resolution was received by the Division on April 3, 2003. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on April 17, 2003 to send additional documentation relevant to the fee dispute as set forth in the rule.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - M – No MAR
   - JX – Fair and reasonable reimbursement for the entire bill is made on the "O/R Service" line item.
   - TM – Services were reimbursed in accordance with the Carrier's fair and reasonable; cost data is unavailable for your facility at the time. Additional reimbursement may be considered up receipt of this information. Will consider additional reimbursement with submission of manufacturer's invoice. Hospital purchase order was submitted with billing
   - O – Denial after reconsideration.
   - T2 – Reduction was made on outpatient bill.
   - YO – Reimbursement was reduced or denied after reconsideration of treatment/service billed.
   - A 19-hour observation was billed. The carrier has allowed its outpatient fair and reasonable for the procedure. No additional payment will be made.

Findings

1. This dispute relates to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 *Texas Register* 4047, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
2. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
3. 28 Texas Administrative Code §133.307(g)(3)(C)(i), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including a statement of the disputed issue(s) that shall include "a description of the healthcare for which payment is in dispute." Review of the submitted documentation finds that the requestor did not provide a description of the healthcare for which payment is in dispute. The Division concludes that the requestor has not met the requirements of §133.307(g)(3)(C)(i).
4. 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
   - The requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated.
   - In support of the requested reimbursement, the requestor submitted a redacted explanation of benefits. However, the requestor did not discuss or explain how the sample EOB supports the requestor's position that additional payment is due. Review of the submitted documentation finds that the requestor did not establish that the sample EOB was for services that are substantially similar to the services in dispute. The carriers' reimbursement methodology is not described on the EOB. Nor did the requestor explain or discuss the sample carriers' methodology or how the payment amount was determined for the sample EOB. The requestor did not discuss whether such payment was typical for such services or for the services in dispute.
   - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
   - The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
   - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January 26, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.